

NOTES ON THREE CASES OF EMPYEMA OF THE MAXILLARY ANTRUM IN WHICH A "BAD SMELL IN THE NOSE" WAS THE ONLY SYMPTOM COMPLAINED OF.

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DURING the recent epidemics of influenza one of the common symptoms was severe catarrh of the nares, often of a purulent or muco-purulent nature. In many cases one or more of the accessory cavities of the nose became affected—the maxillary antrum, the sphenoidal or the ethmoidal cells, most frequently the former. Very few text-books deal at all fully with the diseases of the sphenoidal or ethmoidal cells, and the descriptions of disease of the maxillary antrum are most misleading and exaggerated. We read of exophthalmos, severe pains in the cheek, extensive swelling, copious discharge of offensive pus, &c. These symptoms certainly do occur in acute or severe cases, but in the large majority of cases the symptoms are not at all well marked. Often the patient complains only of a slight offensive discharge from one side of the nares, and frequently the only subjective symptom is a bad smell in the nose. In the three cases which I am recording the patients complained of nothing else except an occasional bad smell in the nose, which was frequently most offensive and disagreeable. Nor were there any marked changes to be found in the nares except slight hypertrophy of the mucous membrane.

CASE 1.—A woman, aged thirty-five years, single, had a severe attack of influenza three years ago, accompanied by muco-purulent rhinitis. Since that time she had noticed an occasional and sickly smell in the right nostril, which varied in frequency and intensity. It was often so offensive that the patient felt sick and miserable. When I saw her in February, 1896, the right nostril was apparently normal, with the exception of some thickening of the mucous membrane. Transillumination gave negative results (as in most cases). An exploratory puncture of the antrum was refused, as the patient said that "she did not wish to be experimented on." In July under chloroform I opened up the antrum through the alveolar process. A few drops of offensive pus escaped. A gold pin was attached to the false teeth, which the patient was wearing, and passed into the antrum. This was syringed out daily, and insufflations of aristol and boric acid were used. The smell disappeared after the operation and has not returned.

CASE 2.—A young woman was sent to me in April, 1897, for "polypi in the right nostril" and an offensive smell in the nose. Eight years previously the patient had all the upper teeth removed because they were loose and painful. Six years ago she first noticed an occasional and offensive smell in the right nostril, which had increased in severity and frequency. There was some hypertrophy of the mucous membrane of the right nostril, but no polypi. I passed a Lichtwitz exploratory trocar through the wall of the lower nasal meatus into the antrum and injected warm boric acid lotion. A large quantity of offensive pus came away through the right nostril, and the patient at once exclaimed, "That is the smell I complain of." The antrum was opened through the alveolar process and treated by insufflations, and recovery followed.

CASE 3.—A married woman, aged sixty-three years, had complained of an occasional and offensive smell in the nose and throat for several years. In the middle meatus of the right nostril there was a pulsating reflex, and on one occasion I could find a little pus in the middle meatus. In May, 1897, I passed a Lichtwitz trocar through the lower nasal meatus into the antrum and injected warm boric acid lotion. A little offensive pus came away; there was no return of the smell until June 4th. On June 10th, under cocaine, I opened up the antrum through the alveolar process. Up to the present there has been no return of the smell.

These three cases seem to prove that empyema of the maxillary antrum often exists without any of the alarming symptoms which are described in text-books. As a matter of fact, cases of disease of the antrum are fairly common, but are in most cases overlooked. I have purposely not

entered into the details of the operation or the etiology of empyema of the maxillary antrum. The less severe cases are most frequently due to disease of the mucous membrane of the nares. I have also avoided entering into the details of differential diagnosis between the diseases of the maxillary antrum and those of the sphenoidal or ethmoidal cells. The symptoms are in many cases very similar.

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Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

AN UNUSUAL INCIDENT IN LITHOTRITY.

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A MAN, aged fifty-two years, was admitted to the Sheffield Royal Hospital on June 21st last for the removal of a vesical calculus of many years' standing. Two days later I proceeded to crush it, but after working for a few minutes the lithotrite jammed with the blades three-fourths of an inch apart. A surgical instrument maker was sent for, but he was unable to liberate the blades, which were, of course, much too far apart to allow of the instrument being withdrawn. The only way of escape from the dilemma appeared to be in performing supra-pubic lithotomy. This was accordingly done, and after removing the stone we succeeded in protruding the blades of the lithotrite through the wound. They were then placed in a vice and pressed together until the female blade fractured. The male blade could now be driven home and the instrument was removed. Had the vice failed us we were prepared to file through the projecting end of the male blade. Owing to the lithotrite being in the urethra the bladder could not be distended; but by using a large rectal bag no difficulty was experienced in reaching the bladder.

The stone, with the crushed debris, weighed one and a half ounces, and was a typical oxalate of lime calculus. The lithotrite was an old one which had seen much service. The patient is doing well.

Sheffield.

NOTE ON A CASE OF RUPTURED DUODENUM; DEATH IN SIXTEEN HOURS.

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ON June 24th last I was called in the evening to see a boy, thirteen years of age, who had been kicked by a horse early in the morning of the same day. I first saw him twelve hours after the infliction of the injury, when his condition was as follows. He was lying in bed upon his back with the hip-joints slightly flexed. His face was pale and wore an anxious expression. He complained of some pain in the lower part of the abdomen, which was slightly distended and very tender. There was no visible bruise or external wound. The abdominal muscles were rigidly contracted, which fact, combined with the tenderness, prevented the acquirement of any information from palpation. The percussion note was quite dull over the whole of the lower part of the abdomen and in the left flank. There was a band of tympanitic resonance below the costal margin and ensiform cartilage, and in the right flank also the note was tympanitic in character. The temperature in the mouth was 102.5°F. The pulse was 140 to the minute, rather small, but not thready. He was quite conscious, and gave me a connected account of the accident. The boy's father, who saw him immediately after the accident, told me that he was soon able to walk some distance up the field in which it had occurred, and then he lay down for some time. Subsequently he was taken home, and after the application of hot flannels he so far recovered that he was able to get about for some hours, and walked upstairs and downstairs. Towards evening he vomited, and he was sent for. Dr. Crosby, of Leicester, who was staying with me, kindly saw the patient, and we passed a catheter, drawing off clear urine without blood. From the symptoms